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NOVEL APPROACHES TO HIV PREVENTION AND SEXUAL HEALTH PROMOTION AMONG GUATEMALAN GAY AND BISEXUAL MEN, MSM, AND TRANSGENDER PERSONS

Scott D. Rhodes, Jorge Alonzo, Lilli Mann, Mario Downs, Florence M. Simán, Mario Andrade, Omar Martinez, Claire Abraham, Guillermo R. Villatoro, and Laura H. Bachmann

The burden of HIV is disproportionate for Guatemalan sexual minorities (e.g., gay and bisexual men, men who have sex with men [MSM], and transgender persons). Our bi-national partnership used authentic approaches to community-based participatory research (CBPR) to identify characteristics of potentially successful programs to prevent HIV and promote sexual health among Guatemalan sexual minorities. Our partnership conducted Spanish-language focus groups with 87 participants who self-identified as male (n = 64) or transgender (n = 23) and individual in-depth interviews with ten formal and informal gay community leaders. Using constant comparison, an approach to grounded theory, we identified 20 characteristics of potentially successful programs to reduce HIV risk, including providing guidance on accessing limited resources; offering supportive dialogue around issues of masculinity, socio-cultural expectations, love, and intimacy; using Mayan values and images; harnessing technology; increasing leadership and advocacy skills; and mobilizing social networks. More research is clearly needed, but participants reported needing and wanting programming and had innovative ideas to prevent HIV exposure and transmission.

Guatemala has a rapidly accelerating HIV epidemic. Although prevalence estimates are imprecise because of a lack of testing resources, low rates of testing among individuals, and poor reporting and surveillance (Barczyk, Garcia, & Casabona, 2010; Cohen, 2006), the national prevalence is estimated to be about 1% (range:

Scott D. Rhodes, PhD, MPH, Jorge Alonzo, JD, Lilli Mann, MPH, Mario Downs, and Claire Abraham are affiliated with the Department of Social Sciences and Health Policy, Division of Public Health Sciences, Wake Forest School of Medicine, Winston-Salem. Scott D. Rhodes, PhD, MPH, and Laura H. Bachmann, MD, MPH, are affiliated with the Section on Infectious Diseases, Wake Forest School of Medicine, Winston-Salem, NC. Florence M. Simán, MPH, is affiliated with El Pueblo, Inc, Raleigh, NC. Mario Andrade is affiliated with APAES-Solidaridad, Guatemala City, Guatemala. Omar Martinez, JD, MPH, is affiliated with Columbia University, HIV Center for Clinical and Behavioral Studies, New York, NY. Guillermo R. Villatoro, MD, is affiliated with Unidad de Epidemiologia, Hospital Roosevelt, Guatemala City, Guatemala.

Address correspondence to Scott D. Rhodes, PhD, MPH, Department of Social Sciences and Health Policy, Division of Public Health Science, Wake Forest University Health Sciences, Medical Center Blvd., Winston-Salem, NC 27157-1063. E-mail: srhodes@wakehealth.edu

0.5–2.7%) among adults. Guatemalan sexual minorities, specifically gay and bisexual men, men who have sex with men (MSM), and transgender persons, are disproportionately affected by HIV, AIDS, and sexually transmitted infections (STIs). It is estimated that there are approximately 30 new HIV infections each day and up to 150,000 people are living with HIV in Guatemala. MSM have approximately ten times the incidence rate compared to the rest of the population (Soto et al., 2007). Prevalence among MSM, including transgendered persons, is estimated to be about 11% while prevalence among male and female sex workers is about 5%.

Moreover, the Guatemalan epidemic is concentrated; 70% of all those with HIV live in Guatemala City, the largest urban area within the country. HIV prevalence among MSM living in Guatemala City is estimated to be as high as 18%. No cases of infection by injecting drug use have been reported (Ministerio de Salud Publica y Asistencia Social Programa Nacional de Prevencion y Control de ITS VIH y SIDA, 2007). Sexual minorities also are disproportionally affected by STIs. For example, gay and bisexual men, MSM, transgender persons, and sex workers and their clients have a consistently high prevalence of syphilis (Zoni, Gonzalez, & Sjogren, 2013).

Very little HIV prevention research has been conducted in Guatemala (Boyce, Barrington, Bolanos, Arandi, & Paz-Bailey, 2012), and overall, no country within Central America has focused research or prevention programming among gay and bisexual men, MSM, and/or transgender persons. Thus, our bi-national community-based participatory research (CBPR) partnership designed this study to identify characteristics of potentially successful programs to prevent HIV exposure and transmission and promote the sexual health of Guatemalan sexual minorities. We wanted to hear what gay men, MSM, and transgender persons in Guatemala City thought was needed to reduce their risks for HIV.

METHODS

THE CBPR PARTNERSHIP

Although all data were collected in Guatemala City, this study was conducted by a bi-national CBPR partnership comprised of lay community members, including Guatemalan self-identified gay men and immigrant Latino gay men living in the United States and organizational representatives, business owners, and academic researchers from both Guatemala and North Carolina. Blending the lived experiences of community members; the experiences of organizational representatives based in ongoing public health practice, outreach, and service provision; and sound science has the potential to develop deeper and more informed understandings of phenomena and identify potential ways to intervene on these phenomena. This improved understanding may yield prevention programming that is more culturally congruent, and more likely to be implemented as planned, maintained over time, and, consequently, successful at promoting positive change in health outcomes (Cashman et al., 2008; Eng et al., 2005; Rhodes, 2012; Rhodes, Duck, Alonzo, Downs, & Aronson, 2013; Rhodes, Hergenrather, et al., 2011; Rhodes, Malow, & Jolly, 2010; Wallerstein et al., 2008). Similarly, study designs, including formative data collection strategies and those used to develop, implement, and evaluate prevention efforts, that are informed by multiple perspectives of a variety of partners may be more authentic to the community and its members' ways of doing things (Rhodes, Duck, et al., 2013).

DEVELOPMENT OF THE U.S.-GUATEMALA PARTNERSHIP

Staff of Asociación de Prevención y Ayuda a Enfermos de SIDA (APAES)-Solidaridad, a nongovernmental organization (NGO) in Guatemala City, provide HIV prevention education, street outreach, and counseling and testing services, and advocate on behalf of those disproportionately impacted by HIV, particularly gay and bisexual men, MSM, transgender persons, and sex workers. While living in Guatemala (1991–1994), the academic research partner (first author) collaborated with APAES-Solidaridad staff to distribute condoms to sex workers. Since that time, the director of APAES-Solidaridad and the academic research partner continued to brainstorm ways in which the sexual health promotion and disease prevention research that was being conducted in North Carolina could serve as a foundation for similar research in Guatemala City. Specifically, the CBPR partnership that the academic partner is part of in North Carolina had several sexual health studies focusing on Latinos in general (Rhodes, 2012; Rhodes, Hergenrather, Bloom, Leichliter, & Montaño, 2009; Rhodes, Kelley, et al., 2012; Rhodes, McCoy, et al., 2011) and Latino gay and bisexual men, MSM, and transgender persons, in particular (Rhodes, 2012; Rhodes, Daniel, et al., 2013; Rhodes, McCoy, et al., 2012).

The academic researcher presented the idea of partnering with staff from APAES-Solidaridad to the North Carolina-based CBPR partnership, and partners agreed that although their focus was on recently arrived immigrant Latinos living in North Carolina, the similarities between communities in North Carolina and Guatemala were profound. North Carolina has one the fastest-growing immigrant Latino populations in the United States. The majority of Latinos in North Carolina come from Mexico, but a substantial number come from Guatemala (Dockterman & Velasco, 2010; Rhodes, McCoy, et al., 2012; U.S. Census Bureau, 2009). To build the partnership, representatives from the emerging bi-national partnership identified other partners within Guatemala. A new organizational partner included representatives from Hospital Roosevelt in Guatemala City. This government-funded hospital has both in-patient and outpatient infectious diseases units specializing in HIV testing, care, and treatment. Other new partners included a gay Guatemalan university professor, three local gay business owners, and three Guatemalan gay men.

Together our newly formed bi-national partnership designed a formative study to explore HIV risk and sexual health among gay men, MSM, and transgender persons in Guatemala City. Throughout the design of the study, partnership members successfully applied published CBPR principles (Israel, Eng, Schulz, & Parker, 2005; Rhodes, 2012; Rhodes, Duck, et al., 2013; Rhodes, Hergenrather, et al., 2011) during each step of the research process—from conception (described above) to study design and conduct, data analysis and interpretation, and the dissemination of findings.

STUDY DESIGN AND CONDUCT

We conducted focus groups and individual in-depth interviews because these qualitative methodologies provide opportunities to investigate participant perspectives more fully than methodologies that use closed-ended questions with predefined response options. These methodologies can reveal key perspectives and nuances that may not be foreseeable. Standardized guides were used to introduce the methodology, outline the focus group or interview process, and lead the discussion. Guide development was an iterative process with representatives from Guatemala and the

United States participating equally. The process included: literature review; brainstorm of potential domains and constructs; and development, review, and revision of questions and probes (for clarification) and prompts (for detail).

The guides, outlined in Table 1, were crafted with careful consideration to wording, sequence, and content.

Demographic data were collected using a brief low-literacy assessment that included: age; country of birth; sexual identity; educational attainment; employment status; current living situation; and sexual behavior with both men and women.

The focus groups and interviews were held in gay-owned restaurants when they were closed to business. Eligibility criteria included being ≥18 years of age; being male and reporting sex with another man since age ≥18 years old or being transgender; living in Guatemala City; speaking Spanish; and providing informed consent. APAES-Solidaridad staff and lay community leaders in Guatemala City coordinated recruitment. Purposive snowball sampling was used to ensure a broad spectrum of participants in the focus groups. Interview participants also were recruited based on their formal and informal leadership roles within the community.

Each focus group and interview also was audio-recorded with participant permission and conducted by one of two native Spanish-speaking gay men from the partnership. These focus group moderators and interviewers were experienced in qualitative cross-cultural sexual health research. The first author and a representative of APAES-Solidaridad served as notetakers. Focus groups and interviews averaged 90 and 45 minutes, respectively. Each participant received dinner and $20.00 U.S. compensation for his or her time.

Human subject review and study oversight were provided by the Institutional Review Board (IRB) of Wake Forest University Health Sciences and El Comité de Ética Independiente Zugueme, the in-country IRB. Signed informed consent was obtained from each participant.

DATA ANALYSIS AND INTERPRETATION

After each focus group, representatives of the study team met to review what was heard during the focus group to develop preliminary codes and themes using constant comparison, an approach to grounded theory (Goetz & LeCompte, 1984; Miles & Huberman, 1994). After focus groups were completed and the team identified preliminary themes, interviews were conducted with formal and informal gay community leaders to gain their perspectives about sexual health, obtain feedback on these emerging themes, and provide further detail and clarification. We used this rapid constant comparison approach given the limited time the research team could be together in Guatemala; although some team members lived in Guatemala City, other members were in-country for only a limited time before returning to the United States.

Focus group discussions and interviews were later transcribed verbatim by a professional transcriptionist. Partners in Guatemala and the United States read, reread, and coded transcripts; refined the preliminary themes; and worked together to interpret themes. Our approach is well-suited for systematically uncovering participants' meanings and furthering interpretive understandings (Charmaz, 2006). Constant comparison combines inductive coding with simultaneous comparison, beginning with initial observations and undergoing continual refinement throughout data collection and analysis (Goetz & LeCompte, 1984). Rather than beginning the inquiry process with a preconceived notion of what was occurring, we focused on understanding the breadth of experiences and building understanding grounded

TABLE 1. Domains and Abbreviated Sample Items From the Focus Group Moderator's and the In-Depth Interview Guides

General health
What kinds of things do you think about when you think about being healthy?
What are your health priorities?
Where do you go for health care?
Sexual health
When you hear of, or think about HIV and AIDS, what do you think about?
What worries about HIV do you have?
What about sexually transmitted diseases? What do you know about them?
How can someone protect himself from these types of illnesses?
Besides using condoms, what do men like yourself do to protect themselves?
What do you do to protect yourself?
Why do some people take risks and others do not?
How does alcohol or other drugs affect sexual risk?
How does religion affect sexual risk?
How does culture affect risk?
You know we are over 30 years into the HIV epidemic, but gay and bisexual men, MSM, and transgender persons continue to be most affected; how would you explain that?
Intervention
What would you do if you were in charge of HIV prevention programming
Probes: Locally? Nationally?
What would you do to keep gay and bisexual men, MSM, and transgender persons safe?
I want you to be creative; what could we do… what should we be doing?
If you wanted to be tested for HIV, where would you go?
What do you think it would be like?
How can gay and bisexual men, MSM, and transgender persons be reached?
Where should we go to reach at-risk men in the community?
Conclusions
What else would you like to share today?

in real-world patterns (Glaser & Strauss, 1967). This approach is especially useful when little is known about a phenomenon (e.g., sexual health among Guatemalan sexual minorities). The goal of the analysis was to identify common themes and not quantify participant experiences (Miles & Huberman, 1994).

We explored sample characteristics using descriptive statistics, including frequencies and percentages or means, and standard deviations (*SD*) using the software SPSS 19.

RESULTS

PARTICIPANTS

We enrolled 87 focus group participants who participated in one of eight focus groups. Mean age of focus group participants was about 28 years old; three-fourths self-identified as male while nearly a quarter self-identified as transgender. Nearly

one half reported more than high school education and 62% reported being currently employed; and 8 reported being sex workers. Nearly three-fourths reported having had multiple male partners in the past three months; mean number of male partners among those reporting multiple male partners in past three months was 7.9.

We also conducted with 10 in-depth interviews; there was no overlap of focus group and interview participants. Interview participants included owners of a gay bar, a restaurant, and a small printing business; a bartender; the managers of a local online social and sexual networking site for sexual minorities and an adult theater; the director of a local NGO focusing on support for those living with HIV and AIDS; a university professor; university student; and a director of an HIV-related community-based organization.

Select characteristics of focus group and interview participants are provided in Table 2.

QUALITATIVE FINDINGS

Qualitative data analysis identified 20 intervention characteristics of potentially successful programs identified by participants to reduce HIV exposure and transmission among Guatemalan sexual minorities. These characteristics are outlined in Table 3.

(1) Fill Knowledge Gaps and Correct Misconceptions. Overall, participants lacked knowledge of sexual health and held profound misconceptions about HIV and STIs. They reported that prevention programs must include basic information to fill knowledge gaps and correct misconceptions about transmission, prevention, care, and treatment. Participants also reported that these knowledge gaps and misconceptions must be corrected before more complex prevention messages can be heard, understood, and put into context. Furthermore, participants wanted to know more about the magnitude of HIV and STIs within Guatemala, Latin America, the United States, and the world; they suggested that overall, there is need for Guatemalans generally, sexual minorities in particular, to know more about the status of the epidemic.

(2) Provide Practical Guidance on Managing Triggers. Participants noted that they wanted and needed practical guidance on managing triggers, such as inconsistent condom use while using alcohol or drugs. Participants noted that alcohol and drug use (e.g., cocaine use was reported to be the most common drug used by Guatemalan sexual minorities) can lead to unprotected sex. A participant commented, "You go out to have a drink or maybe you're using a drug, sex is the next thing you do, I am not joking here, and you don't think about condoms. You don't care about condoms."

Another participant added, "So men will not stop enjoying themselves, but we need help to determine how to manage influences like being at a bar, drinking, or hanging out in the center park where we know unsafe sex sometimes occurs." Participants noted that managing triggers also may include helping gay and bisexual men, MSM, and transgender persons determine where condoms should be kept for convenient access especially given that unprotected sex often occurs in public sex venues including dark rooms of bars/clubs, saunas, public restrooms, movie theaters, parks, and hook-up hotels; whether bars or clubs might be triggers for risk; and how to cope with triggers healthfully.

TABLE 2. Select Characteristics of Focus Group (n = 87) and In-Depth Interview Participants (n = 10)

	Mean ± *SD* or *n* (%), as appropriate	
Characteristic	**Focus group**	**Interview**
Age in years	27.97 (± 8.8; range 18–60)	36.5 (± 7.0; range 23–44)
Country of birth		
Colombia	1 (1.1)	0
Guatemala	81 (93.10	9 (90)
El Salvador	2 (2.2)	0
Honduras	3 (3.5)	0
Venezuela	0	1 (10)
Among those born in Guatemala: Departamento (state) of birth	(n = 81)	(n = 9)
Alta Verapaz	1 (1.2)	0
El Progreso	2 (2.5)	0
El Quiché	1 (1.2)	0
Escuintla	1 (1.2)	0
Guatemala	53 (65.4)	5 (55.6)
Izabal	4 (4.9)	0
Jalapa	1 (1.2)	0
Jutiapa	1 (1.2)	0
Peten	1 (1.2)	0
Quetzaltenango	3 (3.7)	0
Retalhuleu	1 (1.2)	0
Sacatepéquez	0	1 (11.1)
San Marcos	3 (3.7)	0
Santa Rosa	1 (1.2)	1 (11.1)
Suchitepéquez	2 (2.5)	0
Zacapa	2 (2.5)	1 (11.1)
Departmento (state) not reported	7 (8.6)	1 (11.1)
Gender		
Male	64 (73.6)	10 (100)
Male-to-female transgender	21 (24.1)	
Female-to-male transgender	2 (2.3)	
Educational attainment		
None	2 (2.3)	0
Some primary education	4 (4.6)	1 (10)
Primary (Completed 6 years of schooling)	12 (13.8)	2 (20)
Some secondary	10 (11.5)	1 (10)
Secondary (Completed 9 years of schooling)	17 (19.5)	3 (30)
More than secondary	42 (48.3)	3 (30)
Currently employed	54 (62.1)	8 (80)
Current living situation		
Live with male sexual partner	13 (14.9)	
Live with female sexual partner	1 (1.1)	
Live with other family member	34 (39.1)	
Live alone	28 (32.2)	
Other	11 (12.6)	
Multiple male sex partners past 3 months	63 (72.4)	
Mean number of male partners among those reporting multiple male partners past 3 months	7.9 (±9.2; range 2–50)	
Multiple female sex partners past 3 months	6 (6.9)	
Multiple male or female sex partners past 3 months	67 (77.0)	

TABLE 3. Characteristics of Potentially Successful Programs

To reach Guatemalan gay and bisexual men, MSM, and transgender persons to reduce sexual risk and increase HIV and STI testing, interventions should:

1. Fill knowledge gaps and correct misconceptions
2. Provide practical guidance on managing triggers
3. Promote condom use and HIV testing within the context of relationships
4. Provide guidance on how to access limited resources (e.g., HIV and STI testing, condoms, and other services) and "what to expect" when accessing these services
5. Be sex positive
6. Be interactive
7. Increase understanding of living with HIV (what life is like for a Guatemalan HIV+ persons)
8. Offer safe spaces for facilitated and supportive group dialogue around issues of:

- Masculinity/*machismo*
- Sexual scripts, including roles that insertive (tops) and receptive partners (bottoms) play within social and sexual relationships
- Familial, religious, and societal expectations
- The expressions and meanings of love and intimacy among men and transgender persons
- Power dynamics (within "hook-ups" and ongoing relationships)
- Intragroup discrimination

9. Harness existing informal social networks, e.g., be natural helper based and develop culturally congruent and targeted programming to reach distinct subgroups including:

- "Closeted" MSM who may be married to women
- "Out" gay men
- "Weekend" gay men (those who are not out but go out on weekends, may have a network of at least a few gay friends)
- Transgender persons
- Male and transgender sex workers

10. Incorporate Mayan values, languages, and images
11. Build on Guatemalan/Latino values (e.g., familiaismo, dignidad, respeto, colectivismo)
12. Facilitate leadership among gay and bisexual men, MSM, and transgender persons
13. Build capacity to confront machismo, fatalism, homophobia, and discrimination
14. Use technology: local Internet hook-up site, interactive website, Twitter, and Facebook
15. Provide supportive community programming for parents and families
16. Create healthy living options for those with no place to live (e.g., after being kicked out of their homes)
17. Develop conferences and trainings to raise awareness about and instruct providers about culturally congruent approaches to prevention, care, and treatment among gay men, MSM, and transgender individuals
18. Create safe vocational training and educational opportunities to reduce the need to engage in survival sex or other dangerous ways of getting by (e.g., selling drugs)
19. Increase the advocacy skills of gay men, MSM, transgender individuals, and allies to correct misconceptions and reduce discrimination, and increase adherence to confidentiality standards among providers and at service agencies
20. Partner with sexual minorities at universities to build positive images for others and for the community at large (to change the stigma associated with being gay, bisexual, and transgender and engaging in same-sex behavior)

(3) Provide Condom Use and HIV Testing Within the Context of Relationships. Participants reported that prevention programs that include consistent condom use and knowing one's HIV serostatus within the context of one's relationship are needed. Rather than messages that assert consistent condom use, defined as each and every time, participants wanted messages that focus on condom use within the context of relationships. They suggested that those who have multiple partners may need to use condoms to protect themselves and their partners, and those who have one partner may have other options over time. Participants reported that such an approach may resonate with some as sexual minorities establish ongoing relationships and traverse the developmental tasks of relationship building, trust, intimacy, and partnership. Thus, programs must take into account the relationship status and goals of individuals and couples. A participant said, "If you are going to have only one partner and are 'married,' then testing for these diseases can be part of one's commitment to that partner."

(4) Provide Guidance on How to Access Limited Resources. Participants also noted that they need help in learning how to access available resources, including free or low-cost condoms and HIV and STI testing. They reported that they did not understand what was involved in HIV and STI testing; for example, some did not know what biomarkers would be collected. They also suggested that programs should provide guidance on what to expect when they presented for services. As an example, a participant asked whether other patients would be present when he was being examined. Participants also described needing information about their eligibility and rights when accessing services.

(5) Be Sex Positive. Participants suggested that prevention programs must be sex positive; as a participant noted, "I don't want you to focus on what I can't do. I need to focus on me… as a healthy gay man who has sex as a part of being a healthy gay man." Not all participants had such positive self-images or feelings about being gay, bisexual, or transgender and/or engaging in same-sex sexual behavior, but there was agreement that programs must explicitly affirm all identities and behaviors.

(6) Be Interactive. Moreover, participants reported that prevention programs needed to engage them and be interactive. They warned against didactic programming that would remind participants of school; schools were not viewed as comfortable or even safe places for sexual minorities. Participants reported that programs should include icebreakers, activities, and games.

(7) Increase Understanding of Living With HIV. Understanding the experiences of those living with HIV was also identified as key to prevention programming. Participants wanted to know more about what life is like for someone with HIV. They reported that putting a face on HIV could help personalize HIV risk, making HIV real. They had practical questions and wanted to know about infection (e.g., what was going on in the life of someone when they became infected with HIV and how they were diagnosed); the reaction of family and friends; coping strategies; treatment and care options; and how life has changed. They also suggested that being able to put a face on HIV might impact their own stigma around HIV testing and infection.

(8) Offer Safe Spaces for Facilitated and Supportive Group Dialogue. Safe spaces for facilitated supportive dialogue were identified by participants as important. Par-

ticipants wanted opportunities and help to talk about issues relevant to their experiences as sexual minorities such as: masculinity/*machismo*; sexual scripts, including roles that insertive (tops) and receptive partners (bottoms) play within social and sexual relationships; familial, religious, and societal expectations; the expressions and meanings of love and intimacy among men and transgender persons; power dynamics within hook-ups and ongoing relationships; and intragroup discrimination. A participant noted:

> We [sexual minorities] don't have the opportunity to talk [and] relate. No one is there to guide us through living in this world. If you are straight, you have your family; if you are gay, you have no one to turn to or no one who can help you like your family because first you have to feel safe and trust other people. But the truth is that many people who aren't gay won't understand and haven't walked in our shoes.

(9) Harness Existing Informal Social Networks to Reach Subgroups. Participants asserted that prevention programs should harness existing and informal social networks. Participants reported they could help one another learn about HIV and STIs, prevention, and accessing resources like testing and care. Participants suggested that these peers must be trustworthy and discreet; have the potential to be trained to be comfortable offering sound advice about sensitive issues, come into contact with many men because of their social networks or jobs, and be generally helpful to others. Participants acknowledged five distinct subgroups of sexual minorities; each group would need to have their own community health workers (CHWs), peer leaders, or lay health advisors (LHAs); these groups include: (1) closeted men who may be married to women and seek sex with male or transgender partners and/or male or transgender sex workers in public settings and/or through Internet; (2) out gay and bisexual men; (3) gay and bisexual men who are not out about their sexual orientation or behavior to family, work colleagues, and many friends but go to gay bars and clubs on weekends; (4) transgender persons; and (5) male and transgender sex workers. These groups may overlap (and there may be other groups that we did not identify) but emerged as groups at differential risk and requiring different types of programs. For example, closeted men were perceived to be at the highest risk because they may know even less about HIV, often have brief sexual encounters in public venues that do not facilitate condom use, and are perceived as not wanting to use condoms.

(10) Incorporate Mayan Values, Languages, and Images. Participants also suggested that prevention programs may benefit from the incorporation of Mayan values, languages, and images. A participant reported that homosexuality was accepted by some early Mayans; he noted "My understanding is that the Spanish conquest destroyed our civilization, and we lost the acceptance that the Mayans had for homosexuals." Participants concluded that Mayan pride could be used in programming designed to increase the self-esteem and protective behaviors among some sexual minorities.

Although there are >20 Mayan languages spoken in Guatemala, participants reported that the use of Mayan languages and images did not need to be understood by all Guatemalan sexual minorities in the same way; the notion that emerged was to tailor programming to the unique context of Guatemala. A participant noted, "We need to have images that are meaningful for us as Guatemalans, and Mayan images are meaningful even when we don't know what they mean." A participant noted that there remains a strong appreciation for, and effort to protect, the my-

thologies of the Mayans within Guatemala, suggesting, "Perhaps *Ahau Chamahez* [a god of medicine and health] could be used in promoting condoms of gay men in Guatemala."

(11) Build on Guatemalan/Latino Values. Similarly to the inclusion of Mayan values, languages, and images, participants noted that prevention programming should also build on Guatemalan/Latino values. Values that emerged from the data were: *familismo* (familism), *dignidad* (dignity), *respeto* (respect), and *colectivismo* (collectivism). *Familismo* is a strong orientation and commitment toward the family and extended family. *Dignidad* signifies the innate right to be valued and receive ethical treatment. *Respeto* promotes politeness and discretion in interactions, regardless of social position. Finally, *colectivismo* is the idea of the group and tendency to look towards others to help guide decisions and opinions. Participants reported that these values could be used to help support one another within social networks and within communities. A participant noted, "Traditional Guatemalan values are not all bad, familism and collectivism can be used to help us work together, support one another like family, be committed, and take care of ourselves."

(12) Facilitate Leadership Among Sexual Minorities. Participants noted that there is a need to facilitate leadership among sexual minorities. They reported that they thought that some may be interested in building their capacity to community and skills to organize and advocate. A participant said:

> There is a bigger picture than just providing condoms. We need to develop leadership to help each other and create change in society. We need to advocate for resources for ourselves and help society become more progressive and accepting of our communities. We need more integration.

(13) Build Capacity. Similarly, participants suggested that some of this capacity and skills development was needed to effectively confront *machismo*, fatalism, homophobia, stigma, and discrimination. Participants reported that these constructs impact risk and any type of prevention programming—targeting any level, whether individual, family, community, social, or policy—needs to include them. A participant reported:

> This society is hard to live in. As a gay man, one faces feeling of inadequacy and not being a real man. Others hold you in contempt for being gay. You even hate yourself for being gay and not being a man as defined by others.

Another participant added, "And you are discriminated against if people know [you are a sexual minority], and you feel bad about yourself if you aren't honest about who you love."

Besides perceiving discrimination from others, participants also noted a level of intra-group discrimination. They suggested that a hierarchy existed based on social-economic status, skin color, perceived masculinity, and/or racial background within networks of Guatemalan sexual minorities. For example, those perceived to have fewer economic resources, have darker skin, be less masculine, or be more indigenous were reported to have less power in relationships and negotiating safety. A focus group concluded that to prevent HIV, communities of sexual minorities needed to better understand one another and build community, as opposed to do to each

other what those who are not sexual minorities do to them. A participant summed up saying:

> We all face the same harsh world, and we need to learn about one another, find our commonalities, support one another, and work together for change. Our lives are harder because we aren't coming together as one community; in fact, we are being harsh on one another and that is not good.

(14) Use Technology. Participants suggested the potential use of technology to prevent HIV exposure and transmission. Guatemala specific websites that facilitate social and sexual networking among sexual minorities, Twitter, and Facebook were identified as potential places that social marketing campaigns and other types of interventions could be implemented. Although most participants reported not having access to the Internet at home or on cellular telephone, they reported using cyber cafes to access the Internet.

(15) Provide Supportive Community Programming for Parents and Families. Participants reported that parents and families need programming to improve the well-being and health-promoting behaviors of sexual minorities. Many participants reported being thrown out of their houses when family members learned of their sexual or gender orientation and/or sexual behavior. Being without stable housing and family support, they reported, often leads to homelessness, survival sex, depression, and alcohol and drug use—all of which they linked to sexual risk. Thus, participants reported that programming must be developed for parents and families to improve the lives of sexual minorities at home because, as they suggested, changes in the attitudes of parents and families about sexual minorities would lead to reduced risk among sexual minorities.

(16) Create Healthy Living Options for Those With No Place to Live. Participants also recognized that there will always be some parents and families that will not accept their sexual minorities and thus housing options will be needed by some. These housing options are needed to reduce homelessness and survival sex. A participant noted, "Some families aren't going to accept their sons [or daughters], you know, and people need a place that is first safe and then supportive."

(17) Develop Conferences and Trainings for Providers. Participants noted that limited intervention programming, including HIV and STI testing, sometimes exists, but often approaches are not culturally congruent. They suggested that conferences and trainings are needed to raise awareness about the needs and priorities of sexual minorities and to instruct healthcare providers, NGO staff, and educators about culturally congruent approaches to prevention, care, and treatment. Participants noted that understanding and skills are needed to effectively engage and positively affect their well-being and sexual health; they reported that often well-meaning providers, NGO staff, and educators lack the basic understanding of how to use language, be sensitive and supportive, or provide services in a manner that builds their trust to access available services and promotes their disclosure to ensure needs can be met. A participant noted, "I once tried to access services at [name of NGO] and the way the staff looked at me, I felt judged immediately and left."

(18) Create Safe Vocational Training and Educational Opportunities. Because of the potential dangerous ways of surviving on the street (e.g., through selling sex

and/or drugs), participants suggested that there should be programming to provide sexual minorities with vocational training and educational opportunities. A participant noted:

> It can be difficult when you decide that you can't put up with school and the hurt you feel there. Or they kick you out, and then you find yourself on the street having to sell yourself, but if there was a place to go to get trained in something or continue one's education in safer place… that's what is needed to keep me safe.

Another participant noted, "To be with others like me would help me stay on course and not where I am now, doing whatever I have to for money."

(19) Increase Advocacy Skills. Participants reported a sense of responsibility to be part of the change that they reported was needed to improve the contexts in which Guatemalan gay and bisexual men, MSM, and transgender persons live. They wanted to be trained to become better community advocates to ensure that healthcare provision was delivered in a culturally congruent manner. They also discussed their need to advocate for higher ethical standards; for example, some participants talked about the need to improve confidentiality standards among providers and at hospitals, NGOs, and other healthcare agencies. Moreover, participants acknowledged the need to be able to advocate as new issues surface in the future.

(20) Partner With Sexual Minorities at Universities. Finally, participants reported that although somewhat privileged from their perspective, sexual minorities at universities could help promote positive images to change the images and attitudes many nonsexual minorities have. A participant noted, "I can do what I do, but I can't influence those with the power; I only can reach those on the street, but we need to be reaching those who are higher."

DISCUSSION

Currently, there are limited data available on what Guatemalan gay and bisexual men, MSM, and transgender persons report would be potentially successful programming designed to reduce their risk of HIV. This study provides much needed and rich data that can serve as a foundation for subsequent intervention and program development, design, implementation, and evaluation. In this study, 20 themes emerged from the careful and systematic analysis of focus groups and in-depth interview data.

Several findings deserve highlighting. First, participants reported the need for programming to fill knowledge gaps and correct misconceptions about HIV and STI prevention, transmission, care, and treatment. They also highlighted the need for programming to provide guidance on managing triggers especially while using alcohol and drugs and/or being in locations in which sexual risk may be more likely to occur (e.g., dark rooms of bars/clubs, saunas, public restrooms, movie theaters, parks, and hook-up hotels); be sex positive and interactive; and provide guidance on how to access available services and what to expect. The need for filling knowledge gaps, leaning how to manage triggers, and understanding how to access services seem elementary given that we are in the fourth decade of the HIV epidemic; however, this may reflect lack of prevention programming in Central America generally and Guatemala specifically (Rhodes, 2012). Guatemala, for example, does not

have media and social marketing campaigns or other educational efforts designed to increase HIV awareness and knowledge. Thus, Guatemalan sexual minorities do not have a strong foundation on which to build. These types of needs are common among samples of recently arrived immigrant Latinos living in the United States as well (Rhodes, 2012; Rhodes et al., 2009; Rhodes, Daniel, et al., 2013; Rhodes, Hergenrather, et al., 2010; Rhodes, McCoy, et al., 2011).

Participants also reported the need to target various informal social networks through tailored approaches. They felt that harnessing trusted and well-networked peers might be successful in increasing knowledge and changing attitudes and behaviors. Given the existing and unique social and sexual networks that were identified (i.e., closeted MSM, out gay men, weekend gay men, transgender persons, and sex workers), peers might be trained and mobilize to promote sexual health. For example, sex workers may more readily identify with another sex worker who knows the reality of sex work and can provide guidance and support in ways that are authentic to their shared experiences. Sex workers also may be able to reach closeted gay men in ways that out gay men cannot; however, out gay men may be able to reach other out gay men. Moreover, social network interventions have the potential to reach large numbers of community members using approaches and messages that are likely to be the most meaningful to those in their social networks because they share common experiences and perspectives.

Overall, the evidence base linking social network interventions to reduced sexual risk is limited (Wang, Brown, Shen, & Tucker, 2011); however, much is dependent on the selection and training of social network leaders, peer leaders, CHWs, or LHAs (Rhodes, Daniel, et al., 2012; Rhodes et al., 2009), and promising programs that utilize social networks to reduce HIV risk should be further explored and expanded (Eng, Rhodes, & Parker, 2009; Rhodes, Daniel, et al., 2012; Wang et al., 2011).

Furthermore, the majority of Guatemalans are of Mayan decent and some indigenous communities have managed to maintain some of their traditions and languages. In fact, after years of political and cultural upheaval, Guatemala has been able to somewhat protect its Mayan heritage; thus, programming that reflects Mayan values, languages, and images may be effective. This finding reflects another dimension of cultural congruence; HIV prevention programming in the United States has used ethnic group pride as a key moderating or mediating variable in group-level behavioral HIV prevention interventions (e.g., the SiHLE, DiClemente et al., 2004; HoMBReS, Rhodes et al., 2009; and HOLA, Rhodes et al., 2013 interventions), and this may be effective to reach Guatemalan sexual minorities as well.

THE USE OF CBPR

This study was successful in establishing a bi-national partnership through building on the existing strengths of a CBPR partnership in North Carolina. Our trust building included communication through Facebook, text messages, telephone calls, email, and Skype. We also provided compensation for Guatemalan partners to participate in the planning and implementation of this study and in data analysis and interpretation. Community partner compensation is not always included CBPR studies, particularly at early formative stages, but members of our partnership are committed to and have established a history of equitable resource sharing. We also collaborated with Guatemalan experts and conducted a seminar at Hospital Roosevelt in Guatemala City and together appeared on two Guatemalan television stations to discuss the impact of HIV in Guatemala and the study prior to data collec-

tion; these activities illustrated our desire to be team players and work together. We did not want to be viewed as outside experts; rather, we wanted to ensure that each partner's expertise could be highlighted and harnessed.

We were particularly successful in recruiting participants; although we had proposed to collect data from 60 focus group participants, we had 87 participants; in fact, we could have had more participants. This was a result of the trust and the positive reputation of in-country community partners who initiated and coordinated recruitment. We also used a collaborative approach to data analysis, interpretation, and dissemination that we contend led to the increased insightfulness of findings. However, one aspect of dissemination was disappointing. Upon acceptance of our abstract at a conference in the United States, partners were unable to obtain visas to the United States to co-present findings, finalize manuscripts, and plan next steps. Furthermore, over 25% of the participants self-identified as transgender. This high percent is particularly impressive given the stigma and discrimination facing this community in Guatemala.

LIMITATIONS

Participant selection was based on a convenience sample of sexual minorities ages 18 and above and, therefore, the findings cannot be generalized to all Guatemalans; for example, our sample was urban and all spoke Spanish. However, for the purposes of formative research, our findings may inform HIV prevention with sexual minorities from similar communities and backgrounds. Further, although the methods used generated rich qualitative data, the presence of peers during focus groups may have prohibited discussion of stigmatized behaviors, but this study may be a step toward building trust to investigate issues shrouded in stigma and silence. Further research using alternate data collection methodologies, such as more individual in-depth interviews and venue-based intercept assessments, may provide further data and insights into risk within this community.

CONCLUSIONS

With increasing disproportionate rates of HIV among Guatemalan sexual minorities, we must develop, implement, and evaluate interventions with the highest potential of success. In this study, we identified characteristics of potentially successful programs to guide intervention programming for Guatemalan gay and bisexual men, MSM, and transgender persons. We were able to recruit participants who reported a high prevalence of multiple sex partners; nearly three-fourths reported having had multiple male partners in the past three months and the mean number of male partners among those reporting multiple male partners was 7.9. Thus, findings reflect what high-risk participants themselves reported would be effective, and our CBPR approach further helped us ensure that what we found was credible, transferable, and dependable, concepts that correspond to internal validity, external validity, and reliability in quantitative studies (Morse et al., 2011).

More research is clearly needed, but our experiences in Guatemala City taught us that there is a profound need to provide prevention programming. Currently, there is no HIV prevention programming in Guatemala, and sexual minorities who carry a disproportionate burden of HIV and STIs need and want programming. One place to start is with interventions that are being tested within similar communities and adapted using sound approaches.

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